Older Rural Women’s Experiences in Using Rural Mental Health Services

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Abstract

The purpose of this research study was to understand and learn from older rural women’s experiences of using rural mental health services. Older rural women are rarely asked about their experiences in using mental health services. Six women between 60 and 75 years of age were interviewed using van Manen’s method of phenomenology. All the women lived in rural areas and had used rural mental health services in southwest Saskatchewan. The knowledge gained will be used to inform mental health practice, programs, and policy in order to meet the needs of older rural women more effectively. Four main themes were identified: 1) factors leading to the use of mental health services, 2) barriers to mental health services, 3) access to mental health services, and 4) effects of the use of mental health services. A consistent finding was the presence of the social stigma of mental illness and the women’s experience of it in their rural communities. Findings from this project have implications for clinical psychiatric nursing practice, mental health programing and policy to improve care provision, and services for older women living in rural communities. Also, the findings can be used to demonstrate the need for rural mental health services to promote and support the mental health of rural residents and the communities in which they reside.
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Chapter 1 - Introduction

To facilitate and allow individuals to age actively, healthcare planners and decision makers need to develop age-friendly policies and services that protect the most vulnerable adults (Public Health Agency of Canada, 2009). Older adults and older adults with mental illness in rural communities have been examined, yet less is known about older women in rural communities (Leipert & Panazzola, 2013). Older rural women using mental health services in rural communities are often some of the most vulnerable individuals (Leipert, 2005). By understanding the experiences of older rural women using mental health services in rural communities, healthcare clinicians, planners, and decision makers will be better able to anticipate their needs and plan appropriate services.

Although older adults living with mental illnesses most often receive treatment in community settings, the developers and planners of community mental health programs tend to neglect the population of older adults in their program planning (Bédard, Gibbons, & Dubois, 2007). An important aspect of healthy aging is being mentally healthy. Adults, 60 years of age and older, have important mental health needs (Bédard et al., 2007; Futaran & Draper, 2012). Older adults are at risk for anxiety and depression (Vink, Aartsen, & Schoevers, 2008). Those living with mental illness are vulnerable to the exacerbation of physical and mental illnesses as they age (Cronkite et al., 2013). In addition, families of older individuals with mental illnesses require more support than families of younger persons with mental illness (Bédard et al., 2007). Research findings have indicated that older adults experience mental illness differently than younger adults and that their needs differ; yet programs and policies continue to be the same for adults of all ages (Bédard et al., 2007).
In rural and remote regions accessibility to adequate mental health services for older adults has been hampered by the lack of mental health professionals (Robinson et al., 2012). Distance from services is a barrier in accessing adequate mental health services due to the cost of and time taken for travel (Robinson et al., 2012). Experiences of stigma tend to be inflated in rural communities, resulting in increased isolation and loneliness (Robinson et al., 2012). In defining best practices for specialty geriatric mental health services, Sullivan, Kessler, Le Clair, Stolee, and Berta (2004) emphasized the need to understand the local context pertinent to specific geographical areas.

Living in rural communities and being female may interfere with a person aging well (Leipert, 2005). Older rural women without adequate social support to sustain independence, self-reliance, and competence, may experience decreased self-worth (Leipert, 2005). MacKenzie (2001) and Letvak (1997) found that older rural women have a particular relationship to their communities yet less is known about the women using mental health services and their experiences. Leipert and Panazzola (2013) examined mental health issues of older rural women in Ontario and found that lack of resources and losses of people and community infrastructure as well as the debasing of gender, ethnicity, and rurality negatively affected the mental health of older rural women (Leipert & Panazzola, 2013). Further strong correlations exist between being lonely and isolated and ill health (Arbuthnot, Dawson, & Hansen-Ketchum, 2007).

Therefore, when considering the challenges of aging and living with mental health issues in addition to residing in a rural community and being an older female, these women have many factors that must be considered in planning for programs and services to meet their needs. In relating their experiences in living in rural communities and using mental health services, these rural women have much to contribute to our understanding of their situations and their needs.
More research needs to be undertaken and information gathered about the experiences of older rural women who use rural mental health services.

Research Question

The purpose of this research was to understand the experiences of rural women, 60 years of age and older, who had used mental health services in southwest Saskatchewan rural communities. The primary research question was: What is the lived experience of older rural women using mental health services in rural communities in southwest Saskatchewan?

As a practicing psychiatric nurse completing research for a master’s thesis, the primary research question arose from clinical practice and the desire to understand the experiences of these older women. Older women, in particular, have a unique place in rural communities and were the focus of this study. The phenomenological methodology is a research method used to gather information that fits well to gain an understanding of the experience older rural women have had in using mental health services in rural communities. This research project provided an opportunity to identify ways to better provide mental health services to older women living in rural communities.

Next Chapters

Chapter Two contains the literature review of mental health of older adults, rural communities and mental health, and older rural women and mental health undertaken prior to conducting the study. The methodology is described in Chapter Three and the findings are shared in Chapter Four. A discussion of the findings and implications for practice, program development, and policy comprises Chapter Five. Chapter Six is the concluding chapter with limitations of the research and areas for future research.
Chapter 2 - Literature Review

Mental health problems interfere with the ability to grow old successfully. Living with the symptoms of a mental illness interferes with a person’s ability to engage in meaningful activities or to enjoy family and friends (Allan & Dixon, 2009; Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007). Social networks can be out of reach for those living with mental health problems and failed attempts at reaching out may lead to cycles of isolation, aloneness, and disempowerment (Allan & Dixon, 2009; Robinson et al., 2012). Individuals with mental illness who live in rural communities often contend with stigma and social exclusion from others when trying to fit in (Boyd & Parr, 2008). Older women living with mental health problems in rural communities are especially vulnerable because their sense of identity and well-being is tied to the connections they feel with others within their communities (Mackenzie, 2001; Letvak, 1997).

Understanding the experiences of older women using mental health services in rural communities may enable mental health clinicians and program developers to anticipate the needs of clients in order to develop strategies that can facilitate the health and well-being of this population. Literature has been reviewed related to mental health and older adults, rural communities and mental health, as well as older rural women and mental health.

Mental Health of Older Adults

Psychological factors contribute significantly to healthy aging in older adults (Depp & Jeste, 2006; Reichstadt et al., 2007). In addition to longevity, function, independence, and the absence of illness or disability, interrelated psychological aspects of successful aging are identified from qualitative research undertaken with older adults (Reichstadt et al., 2007). A positive attitude facilitates the ability to adapt to age-related physical and environmental stressors. Older adults feel less distress and more secure with stable living arrangements,
sufficient financial resources, and adequate social support. Physical health is considered important to successful aging and negative aspects of ill health can be managed with a positive attitude and a sense of purpose. The ability to remain engaged socially and involved in meaningful activities is part of successful aging (Reichstadt et al., 2007). Yet, for a number of older adults, mental health problems interfere with their ability to age successfully.

Risk factors for anxiety and depression in older adults have been identified (Vink et al., 2008). Prevalence and incidence of anxiety and depression are associated with female gender, a history of mental illness, experiences of stressful life events, and personality traits, such as external locus of control. Insufficient coping techniques and inadequate social support networks are linked to increased risk for anxiety and depression. Increased level of pain, poverty, inadequate support, and daily inactivity are risk factors for depression (Leggett, Zarit, Nguyen, Hoang, & Nguyen, 2012). The risk for depression increases with the number of physical comorbidities, unmarried social status, as well as cognitive and functional limitations (Vink, et al., 2008). In addition, depression often leads to the noncompliance of chronic disease management, which in turn creates a cycle that exacerbates both conditions (Cronkite et al., 2013).

Use of avoidance coping strategies, as opposed to direct adaptive coping strategies, often make problems worse, also contributing to the severity of depression for older adults (Cronkite et al., 2013). Psychological inflexibility, in contrast to an easygoing, calm, and happy disposition, influences ways that individuals deal with stressors, in turn, intensifying the experience of depression (Cronkite et al., 2013). Older adults in rural communities have more chronic conditions and needs related to fulfilling activities of daily living, dealing with memory loss, and managing depression (Baernholdt, Yan, Hinton, Rose, & Mattos, 2012). Although rurality has
been found to be a confounding factor, research findings have been inconsistent as to whether living in rural communities alone affects health-related quality of life (Baernholdt et al., 2012). Older rural women, with inadequate supports and resources, may be the most vulnerable (Leipert, 2005). Knowledge of risk factors and life circumstances contribute to the understanding of mental illness. However, understanding the experiences of older rural women using rural mental health services will build on the knowledge that healthcare workers and program developers have accumulated in anticipating the needs of those using the services.

**Rural Communities and Mental Health**

Each rural community represents a diverse cultural environment in itself. Martin-Matthew and Heuvel (1986) indicated that underlying characteristics contribute to the distinctiveness of rural communities beyond geographical differences related to population distribution, density, and location. Rural refers to more than to just a place to live. In farming communities older adults, through community engagement and relationships built on trust and reciprocity, are important contributors to the creation of social capital and rural sustainability (Heenan, 2010). Communities that were built to attract and support older adults are potentially economically and socially healthier (Thomas, 2007). Availability of local facilities are quality of life indicators and are places for social involvement and support, aspects of rural communities that are often overlooked when health and social policies are being developed (Heenan, 2010). Farmers in southern Saskatchewan experience resiliency from collective rather than individual perspectives (Gerrard, Kulig, & Nowatski, 2004). The response to stress by these rural people is influenced by social, political, and economic factors. In other words, the health of individuals is closely tied to the health of the community. MacKenzie (2001) asserted that the challenges of growing old in rural Saskatchewan includes lack of human and economic capital, reduced
population density, government funding biased towards urban centers, and the perception of self-reliance that keeps people away from accessing formal services.

Help-seeking for mental health issues in rural communities is influenced by lack of services, a belief in self-reliance, and a basic unwillingness to talk about problems (Collins, Winefield, Ward, & Turnbull, 2009; Letvak, 2002). Agrarian values of stoicism and self-efficacy lead to fewer symptoms being reported (Judd et al., 2006; Fuller, Edwards, Procter & Moss, 2000), although women are more likely than the men to seek professional help (Judd, et al., 2006). Individuals living with mental illnesses and their families, who used rural primary healthcare, reflected that living with mental illness comes with significant stigma (Robinson et al., 2012). Feelings of shame and blame for behaviors related to the mental illness keep people away from seeking help and sometimes lead to a sense of invisibility and denial of mental health issues within the community. Denial of mental health problems extends to family members and health professionals and result in the ignoring of symptoms (Robinson e al., 2012). Distance and cost create practical challenges as mental health care often means travel outside of home communities, which hinders accessibility (Robinson et al., 2012).

Solutions to mental health challenges can be inadequate for individuals living with mental illness and their families in rural communities (Robinson et al., 2012). At the community level, for example, police being called to take individuals to mental health facilities has made law enforcement a frontline intervention, which has fueled the stigmatization and stereotyping of mental health clients (Robinson et al., 2012). Families and individuals perceive healthcare services as inadequate when physicians manage mental health issues without referral to specialized services or they overreact to mental health concerns (Robinson et al. 2012). According to research done by Robinson and colleagues (2012) individuals adjust their own
Older rural women's experiences in using rural treatments when solutions are perceived to be insufficient thus creating breaks in prescribed treatment, further adding to a cycle of inadequate care. Mental health problems are sometimes left unanswered due to lack of services, education, or coordination of care so that patients and families feel they are left alone to find their own solutions to their mental health issues. Although the experiences may be similar for rural and urban individuals and families, the social structure in rural communities is such that the experiences of stigma are inflated, creating a cycle of isolation, aloneness, and disempowerment for individuals living with mental illness (Robinson, et al., 2012).

**Older Rural Women and Mental Health**

The need to understand health care needs of rural women and the ways that care can be provided is vital to enabling healthy rural living (Leipert & George, 2008). In rural Australia geographical location is not only a place to live for older rural women, but also “an active and intimate part in their process of ageing, and their maintenance of health and well-being” (de la Rue & Coulson, 2003, p.7). The identities of rural women are often entwined with place, and their sense of community interwoven in the complex network of relationships (Mackenzie, 2001; Letvak, 1997). Further, Letvak (1997) found that older rural women without mental health issues, who perceive their relationships with family to be strong and of good quality even with little personal contact, tend to be satisfied with life. Whereas, women, who perceive a lack of connection to others, are more dissatisfied with life (Letvak, 1997). Although, research results have revealed that rurality may define rural women and influence their coping, less is known about older women using mental health services in rural communities.

Older rural women may be at an increased risk for mental health issues, yet little is known about the factors that undermine their mental health (Panazzola & Leipert, 2013; Vink et
When women lose the ability to drive and are unable to rely on others for transportation, they became isolated, which adds to their feelings of loneliness (Panazzola & Leipert, 2013). Infrastructure issues, such as cracked and uneven sidewalks and streets, contribute to isolation and loneliness as older women stay home for fear of falling when they walk. With the loss of community resources, such as churches, older women have lost places to socialize and be part of their community, which contributes to loss of identity and social supports and exacerbation of mental health issues (Panazzola & Leipert, 2013). Research findings revealed the effect of community values on this population in that older women develop negative self-concepts subsequent to histories of abuse, neglect, and the undervaluing of women (Panazzola & Leipert, 2013). Results from research in Nova Scotia revealed that meeting the psychosocial needs of rural women over 65 was as important as meeting their physical needs for their overall health (Arbuthnot, et al., 2007).

In studies not specific to gender, the researchers found that individuals, who have a mental illness and reside in a rural community, often experience stigma and social exclusion (Boyd & Parr, 2008; Fuller et al., 2000). These individuals are keenly aware of emotional stoicism, lack of anonymity, avoidant neighborly practices, gossip networks, and the fine line between acceptance of eccentricities and rejection of deviancies (Parr, Philo, & Burns, 2004). Ambiguous cultural mores, such as blurred boundaries between inclusion and exclusion, leave individuals with mental health issues in perilous positions, moving from acceptance to rejection very quickly (Parr et al., 2004). Identities of women are closely linked with living in rural communities and the relationships in those communities (Mackenzie, 2001; Letvak, 1997), making it worthwhile to understand the experiences of older rural women who use mental health services in rural communities. Talking with these older rural women will increase our
understanding, knowledge, and insight into the needs of this population, the effectiveness of current strategies used for intervention, and ways to improve programs and services.

Phenomenology is a research method designed to gather information to better understand a particular phenomenon that has been experienced by specific people (van Manen, 2014). In this case, the particular experience to be studied is living with mental illness and using rural mental health services, the specific people are older rural women. Therefore phenomenology is the research methodology that will be used to undertake this study.
Chapter 3 - Methodology

A phenomenological approach provides a method to understand a phenomenon and its meaning from the perspective of those living that experience (van Manen, 2014). “It is precisely the sensibility or meaning of this experiential reality that is at stake in phenomenological inquiry” (van Manen, 2014, p. 21). Phenomenology focuses attention on the places where meanings and understandings begin. Van Manen (2014) described phenomenology as “more a method of questioning, than answering, realizing that insights come to us in the mode of musing, reflective questioning” (p.27). Through truly listening to those with lived experiences, knowledge is gained. Phenomenology provides the means to gain entry to the world as experienced in ordinary life as lived day-to-day (van Manen, 2014). For van Manen the aim of “phenomenology of practice is modest: to nurture a measure of thoughtfulness and tact in the practice of our profession and in everyday life” (van Manen, 2014, p. 31), a fitting approach to gain an understanding of the experiences of older rural women who have used rural mental health services.

Key Terms

For the purpose of this research, the term rural refers to the population outside of the commuting zone of urban centers with populations greater than 10,000 people (duPleissis, Beshiri, Bollman, & Clemenson, 2001). Specific to this research project, the definition of rural includes the populations of all the towns and rural municipalities in the Cypress Health Region (CHR) outside of the commuting zone of the City of Swift Current. A map of the region is included as Appendix A. The phrase, older rural women pertains to women who were older than 60 years of age at the time of the study and who had received rural mental health services while living in a rural community in southwest Saskatchewan.
In the Cypress Health Region rural mental health services refer to services in communities that do not have immediate access to mental health professionals for mental health crises. The services that are provided include case management and/or counseling with a mental health worker, psychiatric nurse or social worker, weekly, twice a month, or monthly. In addition psychiatrists provide follow-up services monthly either in-person or through telehealth. Appointments with mental health professionals take place in five local healthcare facilities otherwise individuals may drive into the city for appointments at the mental health clinic or hospital. When appropriate, psychiatric nurses attend clients’ homes for follow-up services. Immediate and critical mental health services are provided 24-hours a day in the City of Swift Current, which is over three hours away from the most remote areas of the region.

Recruitment of Participants

The focus of this research study was rural women, 60 years of age and older, who had experience in using mental health services in rural southwest Saskatchewan communities. Purposive sampling is used most often in phenomenology to select participants who have experience of living with a particular phenomenon (Streubert & Carpenter, 2011). Mental health clinicians (case-coordinators) received letters explaining the proposed research project (Appendix B). In addition, a letter of invitation (Appendix C) was provided to mental health clinicians to offer to clients who, in the clinician’s assessment, were stable and well, and able to articulate their lived experience of using mental health services in the CHR. In the letter potential participants were asked to express their interest to participate to their clinicians who in turn informed the primary investigator who then called the potential participants to arrange the interviews.
Ethical Considerations

Written informed consent was acquired prior to conducting the first interview, including specific consent to audio recorded interviews (Appendix D). The investigator discussed with each participant the purpose and scope of the research, confidentiality, handling of data, and types of questions to be asked (Streubert & Carpenter, 2011). Opportunity was given to discuss the research and address any questions. Process consent was used to reevaluate each participant’s consent throughout the research process. No clients of the investigator were included in this research study.

An assistant, who signed an oath of confidentiality (Appendix E), transcribed the interviews verbatim. Data were aggregated from all the interviews and shared in such a way that identity of the participants was kept confidential and pseudonyms were used to ensure anonymity of participants. Details of personal data were removed in light of the possibility of identifying individuals in southwest Saskatchewan with minimal information.

Women, 60 years of age and older, who were using rural mental health services and were assessed by their mental health workers as well and stable, were invited to participate. The focus of the research project was on the use of mental health services and steered away from bringing out sensitive material. However interviews have the potential of bringing to the forefront intense feelings. The investigator is an experienced clinician, who was sensitive in these situations during the interview, and was prepared to facilitate contact of the participant with her primary mental health worker or alternate, however the need did not present itself during the course of the interviews.

Procedures and requirements of Brandon University Research Ethics Committee (BUREC) and Cypress Health Region Research Ethics Board (CHR-REB) were followed. The
Tri-Council Course on Research Ethics (TCPS 2: CORE) was completed and certificate is attached (Appendix F). Research began after approval was received from BUREC (Appendix G), and the CHR-REB (Appendix H).

**Data Collection**

The purpose of the phenomenological interview is to explore and gather experiential narratives, stories, or anecdotes (van Manen, 2014). Van Manen (2014) emphasized the need for the interviewer to keep the main research question in mind. The investigator collected data from participants through conversational interviews (van Manen, 2014). Six older women agreed to participate in the study and all six were interviewed. Two interviews were conducted with each participant. The first participant was interviewed in February 2015 and the final participant was interviewed in September 2015. The initial interviews took place either in the home of the participants or an arranged neutral location. Van Manen suggested asking concrete questions about the lived event to facilitate participants in describing their lived experience and steering away from personal interpretation, explanation, or generalization of the event.

The initial interviews were semi-structured with questions to stimulate the participants to bring to mind their lived experiences of using mental health services. The interview guide is included as Appendix I. The length of the initial interviews ranged from one hour to approximately one and a half hours. For this project a subsequent interview was conducted with each participant to check on the participant and to offer an opportunity for her to add any information about the use of rural mental health services. These second interviews, held six to eight weeks after the initial interview, were conducted over the phone with each participant and took less time, from a few minutes up to 30 minutes. The participants offered no further data as they felt they had shared their experience in the first interview. In conversation at the second
No participants appeared to have experienced any concerns related to the first interview and several participants voiced an appreciation at the opportunity to participate and share their experiences. In keeping with the traditional process for conducting phenomenological studies, data were collected and primary and secondary themes were identified through analysis of the transcripts.

Data Analysis

Van Manen (1990) stated that phenomenological research represents the process by which to explore the structure of the human lifeworld, as events and relations enfold everyday. “Our lived experiences and the structures of meanings (themes), in terms of which these lived experiences can be described and interpreted, constitute the immense complexity of the lifeworld” (van Manen, 1990, p. 101). Lifeworld is the experience every person has living each day. As such, persons’ lifeworlds represent the unique complexity of their lives interconnecting with the larger world around them, continuously reshaping and being reshaped by that world. Van Manen (1990) identified four aspects to lifeworld themes that he called existentials. He further suggested that these four existentials (lived space, lived body, lived time, and lived other) facilitate reflection in the research process.

Lived space (spatiality) denotes the subtle and transparent feelings and senses that a person experiences in a particular space, for example the ways that cultural and social mores influence a person living in a rural prairie community that are unique to that space and the experiences of that person in that particular space. Lived body (corporeality) represents the conscious and unconscious experiences and aspects of a person’s physical body interacting with the internal and external aspects of her/his world, for instance the feeling of calm one may have in a safe environment compared to the sense of hypervigilance (feeling anxious) one experiences
in a place in which one feels vulnerable, such as a community clinic reception area while waiting for a mental health appointment. The unarticulated bodily sensations may be experienced in such a way that a person becomes self-conscious and awkward creating a desire to hide and a physical need to pull away which, in turn can lead to isolation and loneliness. Lived time (temporality) signifies the ways that a person feels time and lives temporally, not the time measured by the clock. A young woman with responsibilities, schedules, and possibly young children will experience time quite differently than a woman who, over 60 years of age now reflects back on the realities of her lived life. The present lifeworld is now seen with what has been lived through and what is yet to come with all that the living entails. The fourth existential used to reflect aspects of the lifeworld is the lived other (relationality). Lived other encompasses the preconceived, conceived, and actual interpersonal experiences one has in relation with others in her/his world. Spatiality, corporeality, temporality, and relationality although defined as distinct entities, cannot be separated as together they intricately constitute each person’s lifeworld.

Epoché and reduction (also known as bracketing) are opposing yet complementary processes used in phenomenology by which the researcher suspends his or her presuppositions to facilitate seeing the experience as it exists (van Manen, 2014). As described by van Manen epoché represents the investigator being open to the experience of the phenomena by suspending taken-for-granted ideas and assumptions of the phenomenon being studied. Reduction denotes the opposing force of the process by which the investigator moves back to the phenomena to see it as it is (van Manen, 2014). As a person who grew up, raised a family, and lived on a farm as well as practiced as a psychiatric nurse in rural Saskatchewan most of her life, the investigator attempted to suspend personal memories, experiences, and presuppositions, through awareness and reflection, throughout the present research project.
Data analysis represents the process by which meanings of the lived experiences are retrieved from the words of the key informant (van Manen, 2014). Van Manen described a brief data analysis process as: (a) lived experience description; (b) transformed into a narrative; (c) with theme recognition from wholistic, selective, and detailed readings; and, (d) reflective writing based on the themes (van Manen, 2014). For the present project transcripts of the interviews were read individually and collectively several times to identify primary themes. Notes were made and points highlighted to capture subthemes. Text and themes were put into a table to enable comparisons across transcripts. Writing and rewriting, essential aspects of the phenomenological process as described by van Manen (2014), began after the first interviews to facilitate the grasping of emerging themes. The process was intermittently reviewed with thesis supervisor. Significant themes and statements were identified and then used to write textual descriptions of the participants’ experiences (Creswell, 2013). A composite description revealing the essence of the participants’ experiences in using rural mental health services is presented in the next section.
Chapter 4 - Findings

The Participants

The women who participated ranged from 60 to 75 years of age. Five of the women had lived in their community for over 30 years and one had moved into her community within the last five years. Four of the women had moved to their present community as adults from another part of the province for either their or their spouses’ employment. Two of the women had been born outside of Canada. Three of the six women lived on a farm and three lived in town. All the women had been married once and all but one were still living with their husbands. All but one woman had adult children; one woman never had any children. One woman had family within one-hour distance, for the rest of the women the closest family members were 90 minutes to several hours away. All of the women spoke of experiencing mental health issues that had significantly affected their lives for at least three years. Four of the women talked about having mental health problems before turning 60 years of age. Two of the women talked of mental health issues beginning after the age of 60.

The experiences of older women using mental health services are the focus of this research project. Within the framework of van Manen’s existential concepts interview transcripts were analyzed for primary and secondary themes. Four primary themes identified from the lifeworld experiences of the older women participating in this research project were: 1) factors leading to services, 2) barriers to seeking services, 3) access to mental health services, and 4) effects of mental health services. Within each of these themes, secondary themes or subthemes were identified.
Factors Leading To Services

Physical health issues can be used as analogies to facilitate the understanding and acceptance of mental health issues. For example, health professionals often say that having a mental illness is like having diabetes, an illness that needs to be medically diagnosed and treated. However helpful this comparison may be to normalize mental health issues, the experience of having a mental health issue has a trajectory different from physical ailments with important presages to recognize and acknowledge. The participants in this research project spoke about experiences specific to having mental health issues. The secondary themes identified from the conversations with the women interviewed that eventually led them to access mental health services included: sense of powerlessness, exhaustion, burden carried, and disconnection and isolation.

**Sense of powerlessness.**

A sense of powerlessness means to have “a definite but often vague awareness or impression” of “having no power: unable to do something or to stop something” (Merriam-Webster, 2015). During the interviews all of the six women talked about feelings of powerlessness in one way or another. One woman, Olive, moved from another province hoping that the issues that had haunted her for years would stay back in the previous province, “I thought I was going to leave that behind, but it follows you”. When dealing with a mental illness, such as depression or anxiety, participants spoke of spending an inordinate amount of time trying to fix it, change it, or leave it behind. However, when attempts failed, the sense of powerlessness tended to creep in. Living alone, Doris started to worry about the plumbing problems, uncertain income source, and a cold winter. She spoke of the worrying thoughts going over and over in her mind, then the “not sleeping” began. Stressors, which were manageable as a younger woman,
now seemed insurmountable, leaving her with a sense of powerlessness. The change, losing the ability to cope, made Doris wonder if the cause could be hormones, living alone, or the distance from family; the worry continued. For Doris, differentiating between anxiety and depression was very difficult; worry created a cycle that fed on itself and began interfering with her sleep and appetite. These women spoke of becoming tired, depressed, and finding coping difficult. These experiences seemed to culminate in an underlying sense of powerlessness.

Laura described how the sense of powerlessness crept in as she increasingly relied on her husband to drive her places; she felt “more dependent and less independent”. The doctor had told her things were fine, but she was afraid to drive. Not allowing herself to drive and having to rely on her husband to go to town for her volunteer work, women’s group, and church activities, reinforced her sense of powerlessness. Irene described her depressive episodes as coming and going for years, but with time the frequency of the episodes increased and lasted longer. She spoke of trying to push herself through then she realized that, to raise her family in healthy ways, she could not deal with her mental illness and raise her family at the same time. She recognized a sense of powerlessness and knew that she needed help. For these women, being unable to see a way out of the sense of powerlessness made overcoming mental illness difficult.

**Exhaustion.**

Four of the women interviewed for this project spoke of feeling exhausted. For Isabelle, exhaustion was the accumulation of stress. Years of raising children and living on a farm, driving to adjacent communities for work, and anything beyond basic groceries, meant time on the road. Isabelle expressed a strong connection to her community. Her community was the place where she spent most of her life, first as a child and then as a woman raising her family. However, living here meant she was far away from other resources. She often felt as if she was raising her
family and managing her household on her own because of a limited support system. Looking back on the years, Isabelle stated that she had not realized the toll that the stress had on her until she was “in deep”. The cumulative stress and insomnia that she experienced for years took her on an exhausting path. She shared how only recently had she felt that she was learning to manage that path.

Some participants spoke of how exhaustion came from many years of working hard and others talked about how exhaustion came when too much happened in a short time. Olive talked about feeling overwhelmed, miserable, and depressed. She admitted that moving from another province was, “kind of running away from all the problems”, but in the weeks before moving to Saskatchewan she retired and her mother died. She said that with so much going on for her, she felt overwhelmed. Building up the reserves to fight the exhaustion was difficult once it set in. Idas found that the pressure to get well was exhausting, making her feel even worse. She said that she was running out of places to go, things to do, or options to try. She found herself getting inside her house and doing nothing, curling up on the couch, and staying there, but then she would feel guilt, which for her would lead to anxiety and more exhaustion.

**Burden carried.**

Idas reflected on the burden of living with a mental illness. She found that people lacked understanding of what it meant to be living with a mental illness. She said that she has heard from others that by ‘just’ going for a walk she would feel better, but that had not worked for her so she stopped going for walks. Idas found knowing whom she could be vulnerable with about her mental illness was difficult to determine. She had risked seeking support but after something had been said or occurred that felt uncomfortable, she pulled back, which for her spurred regret and worry. The regret and worry interfered with her sleep. Idas concluded, from other people’s
lack of understanding, that she should avoid showing emotions, “I’m ignored and that is exactly how I feel”. For Idas, the years of managing her mental health had become onerous. She said that as she has gotten older she can look back on her life with depression, and these years of dealing with a mental illness feel like a burden. Memories plagued her of being in hospitals, taking “so many meds”, and all the times that she thought she could not stand another minute of shaking. Burdens, she has told herself many times, that she “should get rid of”.

Living in a small town, Doris felt as if people were talking behind her back, she said that she may not have heard the talk but she felt it, knew it. Going out into the community, where she had lived and worked for most of her life had become so difficult that she had not wanted to go out anymore. She said that she has always found talking to people to be difficult. Because she kept things bottled up, now she does not know how to talk and since turning 60 years old, talking has become even more difficult.

Isabelle also spoke of her experience in bottling her emotions. For her, the burden of work and pushing herself to do more and more, with raising her family and working in adjacent communities, led her to become resentful and angry. She related that in rural communities, volunteerism has kept rinks and schools running, but generosity towards the community often means time away from family. This lack of support was Isabelle’s burden, as she felt that she was raising her family alone because her husband was volunteering, “He was always out on everything”, away from home. She said that she held the anger and resentment inside for years, until after turning 60 years old, she gave herself permission to let go of her bottled up emotions. For Olive, her relationship with her daughters had been irreconcilable for 20 years. The state of the relationships was a burden that she felt deeply, and which, she said, contributed to the sadness that became part of her depression.
Disconnection and isolation.

All of the women spoke about feeling isolated and disconnected from others and having an inadequate support system in some form or another. Some of the women described how feelings of disconnection increased their experiences of isolation in the rural communities in which they lived. Isabelle had retired from her career and her children were busy with their lives away from the farm. Despite living her whole life in her community, she talked about having a limited support system. She had retired and had hoped her husband would also step back from his work, however he was farming more than he ever had. She had exercised with her friends but over time they became more involved in activities with their children and grandchildren living in the same community. This experience emphasized to her that her grandchildren were hours away.

Laura noted, “Things are not like they used to be”. She talked about rural communities changing, with declining populations and fewer people. She recalled a time when neighbors in rural communities knew each other better but now, she noted, there are larger acreages and she does not know her neighbors’ names. Laura depended on the phone to stay in touch with her family and friends overseas, and she depended on her husband to drive her to town for activities. Looking back she said that she had not been driving for three years so she had “not seen her friends so much” and not being able to drive made her depressed. Olive commented, “People tend to leave small towns more than they leave big cities”. She spoke about moving to the community where she lived, “the part of not being from here like, you know, maybe the people who grew up here…everybody knows everybody, and everybody is related to everybody, they have their own things going on, often at a fixed time, these people had years to be around each other, one of the first things people asked us was “ ‘What is your last name?’ ”. Doris had found
that in her community there were very few activities for people her age so she tended to stay at home alone. She found life easier when her children were young; their activities provided a reason to be at the rink, or the school, or any place. The women spoke about finding a place in small communities meaning not only finding physical places to be, but also reasons to be there.

The women spoke of their families as part of their support systems. For Irene coming to terms with her mental health issues had been difficult, “especially when my husband and his family didn’t want anybody to know what I was dealing with…living with that secret wasn’t helping me either”. Irene further explained that when she was “dealing with a deep, deep depression” she felt very isolated. Her statement captures her sense of isolation: “you’re the only one and to reach out is almost impossible on your own”. For Isabelle having a history in her community, living her whole life there, helped her to reach out to friends. She wondered if having had support from her family at crucial times in her life, especially as the children were younger, might have made a difference in her mental health. Perhaps with family support, she would not have felt as if she had to be “too strong…doing everything” on her own.

Idas explained that she has not found anyone, other than her mental health worker, with whom she can talk about her mental illness. She said that she has tried talking to family but faced “a wall” when they lost their patience. The “wall” was upsetting, she explained, causing her to doubt herself to the point that she wanted to give up, an experience that she found very isolating because she had not known a safe person to call for reassurance. Idas found that the expectations that others had of her increased, as she has gotten older. She said, “the expectations of what an older person is supposed to be like, mental illness is not one of them. You aren’t mentally ill until you have Alzheimer’s. You should be this grandma who’s baking cookies and running around doing everything with the grandchildren, doing it all right, not making mistakes, and not
being worried about things”. In speaking about family support the women recognized that demands are high for families to be supportive as are the expectations for each member to function in her/his respective world. Idas said that she felt her family’s support wax and wane.

**Barriers to Seeking Services**

Each woman interviewed experienced barriers to seeking mental health services. Barriers for mental health services represent obstacles that get in the way of appropriate diagnosis, treatment, and care for the person living with a mental health issue. Although barriers may be created in the way that services are structured or provided in rural communities, these women identified personal barriers that kept them from seeking services including: stigma, denial, and perseverance.

**Stigma.**

Five of the six women spoke about experiences relating to the stigma of mental illness. Stigma relating to mental illness consists of negative beliefs about individuals with mental illness, and confirmation of these beliefs and opinions by the community that may evolve into discrimination (Sarkin et al., 2015). Women are especially vulnerable to the negative effects of social stigma of mental illness (Sarkin et al., 2015). At an individual level the impact of stigma can be painful and implacable; keeping individuals away from services that could make their lives more manageable. Isabelle went to her family physician after insomnia had become a problem and she was put on medication. The medication did not help and her anxiety continued for a long time. She concluded, “I was probably so bad, well it worked, but still the dose…for me was not enough”. She continued seeing doctors for medications to manage, all the while trying to handle family and work. “I was a do-it-all person, I had to manage, what else could I do”. Isabelle had not shared her experiences with others to whom she was close. She wondered if she
had been more open, would others around her have reciprocated that openness. Her friends, she knew, would not have rejected her; close friends asked but she said much was left unsaid. She said she knew her family members struggled with the stigma too because her spouse expected her to prove herself “in the world”.

Idas spoke of the pressure that she felt from her family to get well. She said there were times when initially there would be support but then, after a while, she would feel a wall. The message that she said came with the wall was as if to say “Okay, that’s enough now”, which felt to Idas as if they were giving up on her. For Idas, losing that support from her family made her feel like giving up on herself. She understood their frustration; she felt it too. She experienced it all, the medications working then not, being in and out of different hospitals several times, electro-convulsive therapy; she was frustrated and she felt the pressure. Speaking openly about her mental illness with her community mental health nurse (CMHN) was helpful, but she felt awkward when the topic came up in other areas of her life. For instance, the mention in the news media that someone had been in a mental institution had spurred feelings of guilt and shame in her, because she also had spent time in hospitals for mental health issues. Then there were the seemingly well-meaning comments from people, suggesting that they knew she had had “trouble with depression”, that made her wonder, “do they know, how and what do they know, do I tell them more, did they just hear it or…”. She found these situations difficult; she knew that people did not really understand because they did not speak to her directly.

Idas had heard comments made about others with mental health issues, to which she had concluded, “they think that way about me too”. She spoke about the difficulty of explaining that she had not been around for a while because in her small community people noticed and asked. She felt lucky that she had enough physical illnesses to use as reasons for her hospitalizations.
She said that gauging, who she should be in her community, was like a dance she that she has found exhausting. She knew that being involved in activities and staying busy was helpful but feeling emotionally vulnerable and judged had the opposite effect. Idas talked about feeling confused and overwhelmed living with and managing the stigma of mental illness. She said that she recognized that many of her feelings about mental illness had roots in the stories she heard and the experiences she had as a child in her own family. She noted that these impressions, fueled with the stigma of that time, have not been easy to extinguish. For Idas, thinking of others in the community having seen her go for mental health appointments at the community clinic has been difficult.

Olive said that the first time a healthcare provider suggested a referral to mental health services her thoughts were that she was “not bad enough” to see someone from mental health and “someone thinks I am crazy”. Olive noted that the stigma was not necessarily from others but was from within herself. She said that without the healthcare provider having facilitated an appointment with a mental health professional, she might not have gone. She said that likely she would have seen her doctor to start medication and then neglected to pursue further help. Even knowing the progress she had made with the services she received, when she considered being interviewed for this research project, she was cognizant of a pull within herself to keep her mental health issues hidden. Prior to taking antidepressant medication herself Olive had met a friend who had revealed that she was taking antidepressant medication. Olive remembered asking herself whether she wanted that person as a friend or not. Olive talked about overcoming the stigma associated with having a mental illness means more than just challenging the beliefs of others.
Irene recognized that in seeking mental health services in a smaller town people would likely encounter someone they knew in the waiting room, and if this bothered them they would be driving to a larger center or not attending. She said that many people do not want their business to be known by “everybody” and “everybody knows who’s in that room and what you’re going for or who you’re going to see and if you’re not comfortable with that you will be driving” to the city. Irene said that the stigma that she felt from her family held her back from the services that she needed for a long time.

**Denial.**

Three of the women spoke about living with a problem for so long that over time the problem seemed normal; it did not look like a problem. Eventually though, they found that events and situations began to be seen with clarity. Isabelle said that since she has read literature about stress, she can see that her symptoms were stress related, and that the nature of her work had put her at risk for mental health issues. She was aware that she had problems and frustrations; she thought that strife was part of her life. Getting help did not really occur to her. She was busy, not sleeping, and too tired, “that (it could be anxiety) kind of escaped me”.

Olive had regular appointments with a healthcare professional and each time she went she “would sit and cry”. She was doing the same at home. Olive could not figure out what was wrong with her. She said that she had been miserable and depressed, had no energy, and had not wanted to do anything, or see anyone. She had seen a mental health worker prior to moving to this community, yet when mental health services were suggested now, she admitted that she had never thought of these services herself. Olive said that she thinks a lot of women are in denial, she has recognized denial in others. She said that she knows this because she has been there. Doris recognized that she had always worried, but had never thought of worrying as a problem;
worrying was just her way of life. As she looked back she recognized that she had been depressed and should have gone for mental health services two years earlier. She said that she never thought her worry could take her to the point that her mental health was at risk.

**Perseverance.**

Four of the six women spoke about persevering in their lives despite having difficulty managing life. Isabelle said that she did not get psychiatric help right away. She said that not asking for mental health services could have been her fault. She went to her doctor, then, after not sleeping for a week, to a naturopath. She believed that she had to be strong, had to manage; she could not think of any other choice. Towards the end of her career, she would not let herself stop; she had to keep pushing herself through. Isabelle was not sure that she would have asked for help because “we’re too strong”. Olive struggled through without asking for help until she “just could not do it”. Doris said that those close to her knew when they had talked to her on the phone that she was having problems. She thought she would get better on her own and resisted going for help. Irene tried for years to get better on her own until finally she told her obstetrician that she needed help. The women spoke about knowing the time to let go of being “too strong” and ask for help, difficult to discern.

**Access to Mental Health Service Use**

Healthcare decision-makers and policy-developers strive to find ways to create and build systems that facilitate the processes of help-seeking and accessing appropriate services to meet healthcare needs. Across the spectrum of healthcare, healthcare providers should be aware of the ways that people present with mental health problems. Not one of the women interviewed for this research project called Mental Health Services directly, each woman was referred to Mental Health Services through other healthcare providers. Asserted efforts have been made to integrate
mental health with other healthcare services only recently. Considering the ways that the participants in this project engaged in mental health services, two subthemes were identified: referral from healthcare providers and roads and roadblocks.

**Referral from healthcare providers.**

All of the women were referred to mental health services by other health care providers. Idas said that she thought that she was losing her mind after her youngest child was born and she was considering suicide. Believing that “this was wrong”, she saw her doctor who then started the referral process to mental health services. Irene also knew something was wrong at the time of the birth of her youngest child, so she spoke with her obstetrician/gynecologist. When her doctor suggested a referral for mental health services, she knew she needed psychiatric help. However, she talked to the doctor she trusted, not to a care provider at mental health services. Unfortunately, she found the wait between the referral and the call from mental health services to be very long. She began to wonder “how much longer” she was going to be able manage. Laura had no awareness of mental health services, but she knew that she was depressed. Her family doctor told her about mental health services. Isabelle went to her family doctor first because she was not getting her housework done. She was prescribed medication. The medication kept her going, she said, which was not what she believed she needed. She went to a naturopath before eventually seeing a clinician from mental health services.

**Roads and roadblocks.**

Four of the six women recognized that a major concern when living in a rural community is being able to travel to the larger centers where mental health services are available. Idas found that by being in her rural community that her choices were limited as to the services and service providers who were available. Also she had lost her confidence in driving and now relied on her
husband to take her to appointments outside the community, which had become an inconvenience. Irene said that she was glad that her psychiatrist came out to a smaller town especially during farming season otherwise it would have taken the whole day for an appointment. Driving for services was seen as a positive experience for one woman. Isabelle appreciated that she had to travel over 3 hours to and from her mental health appointments, as she viewed the trip as an outing.

Distance and travel from a time and financial cost perspective may be barriers to mental health services yet Olive suggested that these issues might have been used as a means to avoid seeking the services needed, when fear was the real issue. She said that if she had been told that she had to go to a larger center for mental health services, she would not have gone. She recognized that denial was a powerful restrictive force but she was “scared to death” to go for help. She “knew something was wrong but it was just making that first step to go and see somebody”. Olive did not recognize that she might have depression until the homecare nurse mentioned it. She went online and found that she had 15 of the 15 symptoms of depression, yet she became engaged with mental health services when her homecare nurse facilitated the referral.

Effects of Mental Health Services

The experience of living with mental health issues can have profound effects on a person’s life. The delivery of mental health services in rural settings should provide relief from adverse experiences and reduce the impact of living with mental health issues. All the participants in this research project talked about the beneficial effects that using rural mental health services had on their lives. All of the women spoke generally of positive effects of having used these services. However, for these women the positive effects did not erase, necessarily, the
work and struggles inherent in the recovery from mental health issues, particularly in rural communities. Five subthemes of the effects of services were identified: vulnerability of living rurally, control over life, hope and recovery, redefinition of self and purpose, as well as validation and support.

Vulnerability of living rurally.

All of the women spoke about feeling vulnerable living with a mental illness in a rural community. Five of the women spoke about the perception that in rural communities everyone knows everyone else’s business. By attending Mental Health Services in a rural community, a person puts this assumption to the test, a dilemma that must be addressed at a very personal level. Idas was keenly aware of how others talked, she said that she felt judged, an unfortunate effect of seeking Mental Health Services in rural communities. Her CMHN was the one person whom she felt understood her unconditionally. The women talked about choosing to seek mental health services being a difficult predicament with severe consequences. Doris stopped wanting to go out in her community any more. Irene said that she felt lucky that she had a few good years to establish herself in her community before she became ill; otherwise she speculated she might have isolated herself. She talked about the decision she made to overcome the shame of living with a mental illness and realized that, “You have to be a strong person to get out there”. Three of the women spoke about recognizing that the stigma of mental illness was present regardless of the place, urban or rural. In rural communities the chances of being observed while using Mental Health Services were almost impossible to avoid. The women stated feeling emotionally vulnerable could often be a prominent source of this apprehension when they attended appointments.
Control over life.

All of the women spoke of the need for control over their lives in order to be well. Isabelle said that she was “so bad at first” that she did not begin to feel that she could regain control over her life for some time. She had met with a naturopath for alternative treatments, which had represented a turning point in her recovery. Also important in her recovery was connecting with the psychiatrist and a CMHN. She said that she needed to focus on the basics like controlling her breathing and from there she felt that she could get her life back. Most of the women spoke about doing a couple of small activities differently, which started the momentum for them to begin to feel as if they had control over their lives. Olive had a few phrases that she and her CMHN came up with that have stuck with her. If her mind began to wander back to the bad times, she focused on the conversations she had with the CMHN and from there she regained control over her thoughts. Changing the focus from being stuck in her past, to being in the present, facilitated “aha” moments that she will never forget.

Engaging with Mental health Services helped Laura “get back to what I used to be”. She knew she was depressed but she had not realized the extent of her depression. Laura’s CMHN facilitated access to services that included support workers who came into Laura’s home to help her with daily activities, such as cooking, tasks which she had quit doing due to her depression. Irene found that getting better was facilitated when finally she told some friends that she was dealing with mental health issues. Disclosing that she had mental illness was, for her, taking control of her life. Further, Irene said that acknowledging that she had a mental illness had allowed her to get the mental health services that she needed. She was able to compare herself with a mental illness seeing mental health services to a person with diabetes seeing a doctor for diabetes. Asserting herself was another way that she took control of her life. At one time during
her treatment, Irene had her antidepressant medication changed to a different medication with difficult side effects. Her attempts to voice her concerns were unheard by her psychiatrist. She felt defeated. She asserted herself, changed doctors, and started a new medication; she took control of her treatment and her life. Further, in consultation with her CMHN, she was able to develop ideas and plans of ways to get through the days strategically, which helped her to see the health promoting things that she could be doing.

**Hope and recovery.**

Two of the women spoke about how the process of regaining control over their lives spurred hope and recovery. Olive recalled ways that she initially tried to put off the appointment with the CMHN. However, she said that something about that first phone call was motivational; in retrospect she is so glad that she went. In her recovery, she knows that she has to stay busy and “try not to dwell on the negative stuff”. Olive noted that her recovery has taken a concerted effort on her behalf, especially in the rural community where she resides, “you really have to take charge of your mental health”.

Irene talked about medication as an important component of her recovery, as was the talking and processing of her emotions and memories with her CMHN. When she was sick “everything was like a huge mountain to overcome”. Now she shares her experiences with others. She said that sharing her experiences has shown others that a light is at the end of the tunnel and if they stick to a plan they will get through. She knows that with depression sometimes accomplishing any activity can be arduous. She goes for walks and exercises with anyone she knows who is struggling with depression; she has felt better by helping others.
Redefinition of self and purpose.

All of the women spoke of redefining themselves and finding a sense of purpose in their lives. Olive came to the realization that she had to take charge of her mental health, which meant keeping busy and not dwelling on “the negative stuff”. She had found a place that reminds her of the landscape of the province she left, so to satisfy the urge for a road trip she had a place nearby to visit. Further, she had found satisfaction in the unique qualities and charm of the prairie landscape. Irene found fellowship and purpose by volunteering at her Church and engaging in hobbies with other women. She now looks for opportunities to reach out to others. Isabelle considered herself fortunate because she was a natural extrovert and believed that her experiences with mental illness must have happened for a reason. She said that her faith has meant a lot to her. In her recovery she has acknowledged her feelings of anger, recognized the ways that unresolved emotions affected her health, and learned new ways to deal with her stress. She reflected that if she had been more open with others in the past about her mental health issues, if her relationships would have been different.

The women talked about the process of redefining oneself involving change. Doris recognized that she felt isolated being away from her family while living in this rural community. She has been contemplating leaving the town, which she has lived in for close to fifty years, to be closer to her children. For others, the change came from within themselves. Irene found that part of her recovery came as she took a stand, within herself, to reject the stigma of mental illness. She said, “it was a huge part of me getting better; just accepting it and then you know just telling my friends: and this is what it is and this is part of who I am”. Accepting that she had a mental illness enabled Irene to take charge of how she lived. She could easily stay on the farm for days however, she recognized that would not be mentally healthy for her, so she
forced herself to find places to go to be engaged with people. When going for groceries, she said, “Usually there’ll be somebody you can visit with for a while; but that’s a small community, you might not get that if you’re in the city either”. Irene said, “there came a time in my life after so many years and I just said, you know what? I am not going to let my mental health define me as who I am—because that is not me”. She further explained that acknowledging and accepting that she had a mental illness allowed her to do what she needed to do to be healthy, because as she said she is “more than the illness (and) this person needs to have a life too”.

Idas reflected on past years burdened with mental illness and wondered if it would be possible to have a different future now, being only two years younger than the age her father died. Yet as she spoke she recognized, with a lift in her voice, that her mother lived till she was ninety-three and her future could be different than her past. The women spoke about accepting the realities of living with a mental illness and the need to redefine oneself, and that mental illness could complicate cultivating one’s relationships. However, they recognized that having a safe person to support the intricacies of this work was an important and helpful resource.

**Validation and support.**

Four of the six women spoke of the importance of validation and support. Olive recalled that she had “it all bottled up in there” and her CMHN “kind of sat there; you just need someone to talk to, to just kind of look at you straight in the eye”. Olive had met one friend in particular who helped her “through some tough times, she doesn’t give advice, (she) just listens”. Irene had psychiatric care for many years before she knew that having “the extra” counseling was an option. After talking with a CMHN, she noticed fundamental differences in her recovery. With the CMHN she said that she could process her emotions, understand her relationships, and “find the path” of her recovery. Hearing others speak of ways they found to cope and manage mental
health issues in a group was helpful for Laura in her own recovery. She also found that the support from the people in her church community helped her in regaining her mental health.

Five of the women spoke about experiencing support and validation, which enabled them in their recovery from mental health problems. Irene noticed that having lifelong ties to her church helped her to reach out to that community so that “even in the extremely busy times we have time for an hour of coffee and fellowship after service on Sundays”. The church gave Irene a place to go to belong, a place that she felt safe and comfortable, so she could make friends and gain support. She wondered whether she could have managed without her sense of belonging in her “church family”. Although Idas found the validation from her CMHN invaluable, she was unable to find the support she was looking for from her family, without feeling that she was imposing on them. She felt at risk of imposing on the nearby friends too. However, she was able to reconnect with one childhood friend in the last few years. Although in another province, she found a kinship with this person because both had similar experiences that they could share as well as give and receive support from each other.

All of the women in this research project spoke about their experiences of using Mental Health Services in the rural communities in which they lived. The sense of powerlessness and exhaustion of living with mental health issues became heavy burdens that lead to isolation and disconnection from their support systems. In looking back some of the women recognized that by denying and persevering with their mental health issues, they prolonged accessing mental health care. Stigma was found to play a role in the experiences of seeking Mental Health Services in rural communities for these women. Most of the women talked about the need to gauge within themselves the role that stigma would play in their use of the available Mental Health Services. All the women found their way to mental health services through other
healthcare professionals. Rural living represented distance from the larger centers that had access to mental health service options and providers. The women who spoke about traveling outside their home community to access mental health services recognized that distance was a factor. Yet the variable of distance held unique meanings for each woman. For one traveling was an opportunity to leave her community for a day, for another it was a reason to avoid seeking Mental Health Services. Further, the women talked about distance meaning having to rely on others to drive, which hampered their sense of independence. As well, by not traveling there was less choice in mental health services and service providers. The ability to choose whether to drive to a larger center or access mental health service in their community was important. Even with untoward factors related to distance from mental health service options, burdened support systems, and stigma of mental illness experiences, that may have made these women feel vulnerable by living in rural communities, they reported positive recovery experiences. After becoming connected to mental health services the women spoke of feeling validation and support that has facilitated their recovery in redefining themselves, finding purpose, gaining control, and feeling hope increase in their lives.
Chapter 5 - Discussion

Listening to the experiences of the women interviewed for this research project provided a rare opportunity. Insights gained can be used to deepen understanding of the experiences for the benefit of older rural women using rural mental health services in the Cypress Health Region and beyond to further anticipate needs and shape services accordingly. In the previous chapter examples of significant dialogue were used to demonstrate the themes and subthemes of how the six older women experienced using rural mental health services in rural southwest Saskatchewan. In this chapter what they experienced will be explored. The how pertains to the structural description of the experience and what represents the essence of the experience (Creswell, 2013). In the following discussion the dialogue is probed for meanings and explored for the implications of experiences of these older women in relation to nursing practice, program development and implementation, and policy development including identification and management of stigma.

Improving Clinical Psychiatric Nursing Practice

In reviewing the findings, a cycle of powerlessness and exhaustion appears to contribute to feelings of loneliness and isolation. This cycle of powerlessness and exhaustion undermined the rural women’s ability to cope and was further influenced by the stigma of mental illness for some of the women. In attempts to not burden their support systems often the women would carry the burden of their mental health issues alone. The importance of a support system to reduce and mitigate the stress of living with mental health issues became evident. By understanding the experiences of older women in general and rural older women in particular, clinicians will be better able to provide appropriate interventions.
Understanding the cycle of powerlessness and exhaustion.

The women in this research project spoke about different etiologies to their mental health issues. Each woman had a way of understanding the cause of her mental health issue such as having a chemical imbalance, ongoing stress, or the consequences of aging. Yet there existed a commonality to their experiences of living with their mental health issues aside from the causes. Allan and Dixon (2009) found in their research that the experience of depression for older women could create a cycle of self-loathing and a feeling of failure that culminated into a world of isolation and aloneness. The women expressed their sense of powerlessness, an internal experience that undermined each individual’s self-efficacy, self-esteem, and self-worth. A feeling of ineptness became self-fulfilling, as worrying about worry exacerbated anxiety symptoms, and ruminating over losses and the past accentuated the downward spiral of depression.

The experiences of powerlessness and physical exhaustion for these women developed over time, gradually eroding their ability to manage the challenges of their mental health issues. Exhaustion was often identified as a key factor that precipitated the women’s need for mental health services. The women spoke about the ongoing stress of trying to make sense of the thoughts and feelings, which they began to identify as anxiety and depression gradually becoming overwhelming. The overall physical and mental fatigue affected their ability to concentrate, think clearly, and problem solve.

Although all of the women spoke of similar cycles of powerlessness that eventually wore down their ability to cope, each presented a unique accounting of the cycle particular to her own lifeworld. Each woman in this research project spoke of trying to persevere in living with mental health issues without burdening her support system. Failed attempts to find allies and support in
their respective communities added to their burdens of living with mental illness. Over time, however, each of the women managed to find and to build some effective support for themselves.

The women spoke about finding support from different sources and achieving a balance between support from family and from close friends. These relationships were most important in dealing with the loneliness and disconnection, a finding consistent with previous research by Mackenzie (2001) and Letvak (1997).

Letvak (1997) found that missing the feelings of being connected to others coincided with feelings of dissatisfaction with life. In the current project, the women identified a link between feeling connected to others and a sense of well-being, the importance of support and kinship that was reciprocated. Further, four of the women talked about feeling validated, through the therapeutic relationship with their CMHN, which in turn normalized their experiences of disconnection and isolation, enabling them to examine their situations to find ways of coping.

**Providing appropriate psychiatric nursing care.**

The sense of powerlessness crept in for the women. In other areas of their lives or in the past, they had been able to overcome adversity. There had been hopes that with growing older things would be easier. Being unable to cope and feeling pressure from others became exhausting. The women shared that feeling disconnected and isolated made it difficult to achieve adequate levels of functioning. Listening to the stories of these women also revealed strategies and interventions, which for them generated change.

The partnership that was established through the therapeutic relationship allowed each woman to feel hope, and with the hope that she could feel better again, recovery began. With validation and support, the women in the current study were able to accomplish some of the most
difficult aspects of recovery, the process of redefining themselves and finding a sense of purpose in their lives. Clinicians sometimes put emphasis on which therapeutic model to use, yet for the women interviewed, having someone with whom they were in partnership through their recovery, mattered most. New tools were gained such as self-care strategies, cognitive self-control, and breathing techniques. Yet, as Olive stated, having someone to “look at you straight in the eye” made the difference for her. These research participants revealed that within the therapeutic relationship, time spent and trust built between the client and her psychiatric nurse or mental health worker, were fundamental to effective recovery.

Gaining some sense of control in their everyday lives started the ascent to recovery. The women talked about starting at the basics like controlling breathing and doing a couple of small activities differently, which started the shift. Taking small steps to feel some success enabled the confidence to be able to go on. Some of the women reported that certain activities or phrases helped them feel a sense of control over their lives. Various therapeutic strategies were used to treat the mental illnesses experienced by these women. Using assertiveness skills and developing strategic plans for day-to-day activities represented crucial turning points in Irene’s recovery. A sense of control over one’s life was essential to wellness.

Group activities that have an educational component, an exercise activity, and a social support aspect have been shown to be successful in helping individuals to deal with loneliness and in assisting older adults to avoid mental health issues such as depression and anxiety symptoms (Perese, 2012). Such groups are not readily available in rural communities, as the experiences of the older women in this research project revealed. The experiences of these women demonstrated that finding opportunities to feel success in their lives was important to their recoveries, such as, interventions that provided in-home support to aid in undertaking daily
The findings of this project can be used to emphasize that within a therapeutic relationship, mental health clinicians need to have a strong understanding of the client, her relationships with family and friends, and ways that the client relates to the rural community within which she lives. Such understanding is pivotal in order to work with the client to identify and create the interventions that enable her to redefine herself and find purpose.

Keeping busy and not dwelling on the past, finding new spaces and places to connect with nature and spirituality, staying connected to sound social supports, rejecting stigma, seeking and accepting change were some of the ways the women in the current study talked about redefining themselves and finding purpose. The psychiatric nurses or mental health clinicians provided therapeutic interventions that strengthened each woman’s ability to navigate the intricacies of her world that facilitated self-acceptance, self-esteem, and self worth.

Several psychotherapy approaches that have been found to be effective for older adults include ones that focus on behavioral and cognitive restructuring; life reflection, the aging process and building a sense of self-continuity; problem-solving therapy; and changing role and relationship integration (Wheeler, 2014). Wheeler (2014) indicated that developing a therapeutic relationship in nursing encompasses the ability to convey empathy and understanding, accept individuality, maintain boundaries, as well as the capacity to be supportive and present, genuine, respectful, and self-aware. As previously mentioned, findings from the current research project underscore the significance of the therapeutic relationship in helping these older rural women, yet psychiatric nurses need to stay abreast of advances in evidence-based approaches for older adults to ensure the provision of effective care to achieve desired patient-centered outcomes.
Each woman’s experience of the burden of living with a mental illness was dependent on her sense of connection within her family or those close to her within her community. It is important for psychiatric nurses to work with individuals to find solutions that enable each person to build effective support systems from the resources available and to address his/her specific needs. Finding a place, which felt emotionally safe, was integral to each woman’s recovery in the current study, an important consideration for clinicians to incorporate into individual treatment plans. For someone very aware and sensitive to the social stigma of mental illness to “just” go for a walk or get involved in activities as part of recovery was too difficult. Yet, pushing oneself to take a stand for one’s well being helps in overcoming the detrimental effect of the stigma.

Understanding, that stigma will affect each individual differently and addressing the ways in which persons respond to their experience of stigma, is an important aspect of individual treatment. Further, overcoming the negative repercussions of stigma enables others to be more open, which can facilitate the building of a support system, as Irene demonstrated. Psychiatric nurses need to help clients, through the use of cognitive and behavioral interventions, to examine their attitudes and behaviors that prevent them from finding the supports that can facilitate their optimal mental health. By identifying and addressing the impact of stigma of mental illness has in the woman’s life, the mental health clinician facilitates the client in making her mental health a priority, thus allowing her to do the activities that ultimately promote her mental health.

Providing access to mental health clinicians in rural communities is key to ensuring the opportunity for the development of therapeutic relationships and individual counselling. The provision of appropriate programs to complement and supplement such care is important in the
delivery of effective rural mental health services and in the promotion of the mental health and wellbeing of rural residents and their communities.

**Developing and Implementing Appropriate Programs**

Understanding the lifeworld of older rural women using rural mental health services can help clinicians and program developers determine ways to shape services. Access to mental health services needs to take into account the initial contact with mental health care providers as well as accessibility to ongoing mental health services for individuals with chronic mental health conditions. Ensuring access to mental health services facilitates the implementation of timely interventions that can minimize or prevent the exacerbation of mental health issues. Such services should include interventions and treatment as well as health promotion and prevention aspects of program development.

**Patient-centered programs to promote mental health.**

Findings of the current research project revealed that the sense of powerlessness and exhaustion undermined the coping ability of the women, which in turn contributed to their need for mental health services. Understanding the ways that ongoing stress affects an individual’s ability to cope is an important insight that indicates the need to prevent mental illness and reduce the impact of living with mental health issues. Addressing critical factors to prevent the exacerbation of mental distress will improve the quality of life of older rural women. Factors experienced by adults that may be responsive to change are self-control abilities, goal-oriented behavior, stress-management skills, support system quality, and resilience, as well as faith and spirituality (Perese, 2012). As such, intervening early in the cycle of stress (the sense of powerlessness, and mental and physical exhaustion, which lead to isolation and an inability to
cope) would reduce the cumulative effects that stress and ineffective coping have on an individual’s mental health.

Mental health interventions and programs, which are designed to strengthen coping mechanisms, enable involvement in meaningful activities, facilitate social support and engagement, and teach informed-decision-making, are important ways to support successful aging (Wheeler, 2014). It was also emphasized from the stories of the women that the goal of services should be to focus on recovery rather than the number of sessions or treatment modality. Clinicians working in rural communities must be supported through appropriate supervision and access to ongoing education to stay abreast of new knowledge and evidence-based psychotherapeutic interventions that facilitate optimal mental health for older women. Such education should also contribute to clinicians’ ability to develop and implement mental health programs and services.

The focus of prevention in the mental health field has shifted to preventing mental illnesses across the lifespan and improving mental health promotion (Perese, 2012). Mental health promotion and mental illness prevention are distinct yet interrelated approaches (World Health Organization (WHO), 2004). Prevention of mental illness incorporates mental health promotion strategies, which may in turn reduce the incidence of mental illnesses (WHO, 2004). Mental health promotion strategies are community based, address the health needs of the whole population, and are built on the premise that the causes of health and illness are multifactorial, complex, and interrelated (Kobus-Matthews et al, 2010). Mental health promotion incorporates approaches that build the abilities of individuals and communities to improve their mental health, take control of their lives, and build individual resilience (Kobus-Matthews et al, 2010). Mental
health promotion strategies target the whole population and include public education, parenting skills, stigma reduction and resilience building (Perese, 2012).

Prevention of mental illnesses in older adults includes protective and risk factors (Perese, 2012). Protective factors, which have been shown to prevent mental illness in older adults include being married; participating in physical and mental activity; completing more advanced education; and having financial resources, social engagement, and physical health (Perese, 2012). The factors that increase the risk of mental illness include: poor physical health, polypharmacy use, bereavement, poverty, poor social network, under-nutrition, and elder abuse (Perese, 2012) Education programing aimed at the prevention of mental illness should incorporate these topics and be directed towards older adults, care providers, and the public.

Financial and human resources invested in the prevention of mental illness and mental health promotion provide benefits at an individual, family, and community level and should be a priority in mental health program planning.

**Access to rural mental health services.**

None of the women interviewed for this research project entered mental health services directly; each woman accessed mental health services through a primary health care provider. Accessing mental health services through health professionals, outside of mental health services, is consistent with the report by Stockdale Winder (2014). This finding can be used to emphasize the need for further education of primary health care providers and members of the community regarding available mental health programs and services as well as ways to access those programs and services. Programs such as Mental Health First Aid (Mental Health Commission of Canada, 2011) should be made available to healthcare workers as well as family and community
members to improve mental health literacy and teach skills and knowledge of ways to help individuals deal with mental ill health issues and to facilitate accessing appropriate help.

Access to mental health services in rural communities was important for the women in this research project. Although, some of the women were willing and able to travel, without access to mental health services locally, such as counseling, case management, and psychiatric services, some of these women would have gone without appropriate help. The women understood the unique challenges to rural service delivery, such as lack of anonymity and limited availability or choice of service provider in their respective communities, yet the service needed to be available there. Saskatchewan’s appointed mental health and addiction commissioner, Fern Stockdale Winder (2014), stated that mental health services should be accessible in rural communities. Further, Stockdale Winder recommended that technology be used in these communities to ensure access to services. One participant spoke of the use of telepsychiatry and was open to the enhancement of in-person rural services that included appropriate use of online resources and telehealth, as long as confidentiality was maintained and therapeutic effectiveness was assured when clinicians known to the client were involved.

Intervention services for treatment must be available to rural residents, while mental health promotion programs and services must also be developed and implemented. These programs must be patient-centred and delivered with an understanding of rural people, rural life, and rural communities. The mental health needs of older rural residents in general and older rural women in particular must be included in this planning and delivery.

**Developing Informed Mental Health Policy**

The purpose of the current research project was to understand rural women’s use of mental health services with the intent to inform practice, programing, and policy. Six women
were interviewed to gather data to understand their experiences. No particular policy implications were discussed directly by the participants. However the importance of providing and maintaining rural mental health services was identified. Findings from the current research project also revealed that stigma of mental illness had an impact on ways that mental health services were utilized.

**Identifying and managing stigma.**

Sarkin et al. (2015) explicated three components of stigma: negative beliefs held by others, confirmation of the beliefs, and opinions that may lead to discrimination. Sarkin et al. (2015) found that women and youth were especially vulnerable to the negative effects of social stigma of mental illness. Negative effects of stigma of mental illness were evident in the women’s experiences in this research project. The women spoke about their experiences of mental health issues that led them to services. Misdiagnosis and inadequate treatment may be examples of the social stigma of mental illness. Lack of understanding, from professionals as well as family members, underscored adverse experiences of stigma. It is difficult to imagine another illness where an individual would have to prove his/herself over and over in the world. Some of the women articulated experiences related to the social stigma of mental illness exhibited by family members as well as community members. One woman voiced her own feelings of stigma and the impact on her thoughts and plans. Another spoke about the impact that the negative messages she received as a child had on her ability to overcome the debilitating effects of the social stigma of mental illness. Stigma as discussed by these women was complex and powerful.

Findings from the current research would indicate that negative beliefs held by persons themselves also play a role in the impact of stigma. Denial and perseverance were identified,
during this research project, as barriers to accessing mental health services. Both denial and perseverance may be closely linked to the stigma of mental illness, yet they stand out as experiences that kept some of the women from accessing mental health services.

Living with mental illness has been associated with the experience of significant shame in rural communities (Robinson et al., 2012), an experience also voiced by some of the women in this present research project. The women’s articulated experiences of stigma closely mirrored the research findings of Robinson and his group (2012), that is, in rural communities experiences of stigma were exaggerated to the point of creating a cycle of isolation, aloneness, and disempowerment.

The negative impact of stigma is compounded as families also experience the social stigma of mental illness. Data from the present research project indicated that the stigma of mental illness contributed to the subjective experience of living with a mental illness. Some of the women interviewed talked about the burden of living with a mental illness in her respective rural community. They believed the impact of stigma toward mental illness had negatively affected relationships with others. Parr et al. (2004) discussed the ways that individuals with mental illnesses move from acceptance to rejection in rural communities very quickly. Stigma must be considered at individual and family levels in terms of psychiatric nursing care. Stigma must also be included as a component at a program level with mental health education being provided in schools and to other community institutions and organizations. Support and education for family members of individuals living with mental illness needs to be made available on an ongoing basis, ensuring attention to the effects of social stigma on the individual and the family. Further policy related to the reduction of stigma through mental health promotion and education should be developed and applied at the community level for all communities.
Health promotion strategies need to include rural communities, which are often less adequately resourced and less densely populated.

**Evidence-informed mental health policy.**

Although this research project focused on older rural women, mental health services need to incorporate guiding policies that support the well being of all people. Several broad policy directives from the mental health commission are specific to older adults and are supported by the findings of the present research project. The Mental Health Commission (MacCourt, Wilson, & Tourigny-Rivard, 2011) advocates for service delivery models that ensure mental health needs of older adults are at the forefront for healthcare planners and decision makers. Pertinent policies outlined by the Mental Health Commission state that:

- In developing an integrated mental health system, policy and decision makers need to, understand the diversity of seniors, local contexts and resources, and the need for existing practices and relationships (among care providers and systems) to change.
- All policies, programs, and services should be measured through the Seniors Mental Health Policy Lens (a framework used to assess the level that policies promote and support senior mental health).
- All policies, programs, and services should be embedded with mental health promotion, with strategies for anti stigma, public awareness, training, and education.
- Older adults, care providers, the public, and service providers should be educated regarding the need of early detection of symptoms of mental illness, strategies for prevention, and recovery oriented services (based on hope, empowerment, and choice).
Although particular aspects of integrated mental health systems depend on local needs and resources, the system should provide access for the whole senior population with support services that are community-based, incorporate primary health care, consist of general and specialized older adult mental health services, and establish mechanisms that facilitate collaborative care and access to mental health services (MacCourt et al., 2011).

These goals must be considered in rural programming and applied in rural communities for the benefit and mental wellbeing of rural residents and their communities.
Chapter 6 - Conclusion

The perspectives of six rural women over 60 years of age who have used rural mental health services in southwest Saskatchewan were shared. These findings do not necessarily represent the views of other older women in the region. A phenomenological approach provides a means to gain knowledge by listening to those persons with specific lived experiences. The aim and strength of phenomenology is not to acquire generalizable data but to uncover and see through the assumptions and presumptions that “shape our understanding of the world and understanding of life” (van Manen, 2014, p. 55). The results of this research project can be used to provide an initial picture of the experiences of older rural women in their use of rural mental health services. Insights gained from this research project can be used to develop treatment plans for individuals living with mental health issues and to support their families, as well as to help plan services and programs.

There were limitations of note in this research project. In using the purposive sampling method the principal investigator had psychiatric nurses, and other mental health clinicians, working with appropriate clients and having interest in this research project refer participants. Other potential participants, who might have had different perspectives, were not given a voice or heard. The number of participants was limited to those who were referred. Although the data was rich, the inclusion of more participants would have added further quantity of responses and may have contributed to the expansion of or enhanced quality of responses. This research project was focused on rural older women who have used rural Mental Health Services. Other individuals affected by these services were not included. Family members, allied health professionals or care providers such as spiritual and religious caregivers, homecare workers, and
mental health clinicians also have perspectives that could have shed further light on the use of rural Mental Health Services.

Another limitation to note is that in qualitative research the researcher is part of the research process (Creswell, 2013), as such, results are specific to that researcher and another person may have interpreted and understood the data differently. Finally, although the researcher is an experienced clinician, she is a novice researcher. Therefore, the techniques and skills used in the process of this research project, from interviewing to writing stages, may be seen as rudimentary and limited.

The women interviewed for this research project provided insight into their experiences in using mental health services in CHR, sharing their positive experiences as well as the barriers and difficulties that they experienced. It is unknown whether the perspectives of the women in this research project can be generalized to other women using rural mental health services. Future research may examine these aspects.

A consistent finding from the participants was the presence of social stigma of mental illness in their rural community. Social stigma of mental illness was revealed to be a complex phenomenon for the women in this research project, and the ways each woman was impacted and dealt with it were unique. Experiences of social stigma for the older women in the rural communities of CHR were influenced by past and present events. Future research exploring the experiences of social stigma in these rural communities, for individuals living with mental health issues and their families, would be valuable to gaining important insights and knowledge. Finally, another area to explore in future research that arose from the interviews with the women in this project was the use of technology in providing rural mental health services.
For the frontline mental health clinician, this research revealed the importance of listening to each client in order to find the specific ways for each person to feel success in her lifeworld. It was evident from the research findings that rural older women in rural communities are not a homogeneous group; each person had unique experiences of mental illness with individual paths in recovery.

Skills, knowledge, and techniques gained from the interactions with mental health clinicians provided means to an end for these women, the ability to fully participate in their lives and to age successfully. Each woman brought her own lifeworld experiences of living in her particular community. It is important for clinicians to understand each person’s perspective in order to facilitate growth building the skills necessary to navigate the challenges of living mobilizing resources and supports in that particular rural community. A host of skills is required and may entail specific problem solving work in developing and finding emotionally safe places that extend beyond the therapeutic relationship. Ongoing support and education for family members of individuals living with mental illness should be made available; education that includes a component on the effects of social stigma on the individual and the family.

For healthcare planners and decision makers this research project brings to the forefront the voices of older women, who have utilized Mental Health Services in rural southwest Saskatchewan. It is understood that Mental Health Services in rural areas will have fewer options regarding clinicians and access to programs, however findings from this research project indicated that services are vital in the smaller rural communities. There is a need for creative and flexible ways to provide services. Use of telehealth technology potentially can be a viable means of service delivery as long as safety, confidentiality, therapeutic effectiveness, and client perspectives are incorporated into its use. Concerted effort is needed to ensure that primary
health care providers and other service providers know how to connect individuals to mental health services and how to work collaboratively with mental health services. In addition to intervention services and programs, mental health promotion and education must be made available in rural communities. It is paramount that program developers and policy makers are sensitive to the factors that are unique to rural communities, with particular consideration of the issues that cause individuals to be vulnerable while accessing mental health services in rural communities.

The women in this study have provided insights about being older, living with mental health challenges, and accessing mental health services while residing in rural communities. Their stories and their willingness to share them have been valuable and are much appreciated.
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OLDER RURAL WOMEN’S EXPERIENCES IN USING RURAL

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interventions and policy options. Summary report/a report of the World Health
Appendix B

(Letter to be placed on Brandon University Health Studies letterhead)

Letter to Case-coordinators

Dear Case-coordinator,

I am conducting a research project to understand the experiences of rural women over 60 years of age in using rural mental health services outside the city of Swift Current. I am seeking participants to meet with me to share their experiences so that I can gain an understanding of their use of mental health services in rural communities. The knowledge shared may be used for future programming and policy development. This study is part of my Masters of Psychiatric Nursing degree in the Faculty of Health Studies at Brandon University, Brandon, Manitoba under the supervision of Dr. Fran Racher.

Participation in this study is voluntary. Please assure your clients that participation in this research project will not affect any services they may be using now or in the future. Two interviews will be conducted with participants in their home or a mutually agreed upon location. Rather than having you explain the fine details of the project, please find enclosed a letter of invitation that provides written information regarding participation in this research project. Please offer this letter to your female clients who are 60 years of age or older and, in your assessment, are stable, well, and able to articulate their lived experience of using rural mental health services. Potential participants may express their interest to participate either to you, and I will contact them, or to me directly at 306-778-5267 or by email at mkren@sasktel.net.

Thank you for your interest and your time. If you have any questions regarding this study, or you would like additional information please do not hesitate to contact me.

Kind regards,

Mary K Renwick RPN/BScPN
Masters of Psychiatric Nursing (student)
Faculty Health Studies
Brandon University
Appendix C

(Letter to be placed on Brandon University Health Studies letterhead)
Letter of Invitation

Dear Madam,

This letter is an invitation for you to consider participating in a study that I am conducting to understand the experiences of older women in using rural mental health services. I am seeking participants to meet with me to share their experiences so that I can gain an understanding of their use of mental health services in rural communities. The specific focus of this research project is on individuals’ use of mental health services. The knowledge that you share may be used for future programming and policy development.

I am not initiating contact with you on behalf of the Cypress Health Region or your primary care provider, but as a student researcher from Brandon University. This study is part of my Masters of Psychiatric Nursing degree in the Faculty of Health Studies at Brandon University, Brandon, Manitoba under the supervision of Dr. Fran Racher. The findings of this research will be compiled in my thesis report, which is part of the necessary requirements in completing my degree and may be published in appropriate academic journal(s). I would like to provide you with more information about this project and your possible involvement.

Participation in this study is voluntary and will not affect any services that you may be using now or in the future. Participation will involve two interviews. The first interview will be approximately one and a half hours in length, and the second will be about one-hour.

The interview will take place in your home or a mutually agreed upon location. You may decline to answer any of the interview questions or withdraw from this study at any time without any negative consequences. With your permission, the interview will be audio-recorded to facilitate collection of information, which will be transcribed for analysis. Your involvement and all information you provide are considered completely confidential. Your anonymity will be maintained through the use of a pseudonym or false name. Data that are collected during this study will be retained on a computer and password protected. Printed transcripts will be kept in a locked cabinet. Only the researcher, her supervisor and the transcriber will have access to the audio-recordings associated with this project. There are no known or anticipated risks to you as a participant in this study.
If you are interested and willing to consider participating, you may give your name and phone number to the mental health worker who has given this letter to you and I will contact you by phone. You may also contact me directly at the phone number or email included below. When we talk I will describe the project to you and should you decide to participate we can schedule a meeting to discuss the project further and complete the first interview.

Thank for your interest and your time. If you have any questions regarding this study, or you would like additional information to assist you in reaching a decision about participation, please do not hesitate to contact me at (306) 778-5267 or by e-mail at mkren@sasktel.net. You may also contact my supervisor, Dr. Fran Racher at (204) 728-4747 or by e-mail at racher@brandonu.ca.

Kind regards,

Mary K Renwick RPN/BScPN
Masters of Psychiatric Nursing (student)
Faculty Health Studies
Brandon University
I am interested in participating in a study to share my experiences and reflections on my experiences of using mental health services in a rural community in Southwest Saskatchewan. The knowledge that I will share will contribute to the understanding of mental health services in rural communities and may be used for future programming and policy development. I am aware that I am not participating in this project on behalf of the Cypress Health Region or my primary mental health care provider, but as a participant in a research project by a student researcher (Mary K Renwick) from Brandon University. I understand that the findings of this research will be compiled in a thesis report, which is part of the necessary requirements for Mary K Renwick to complete her degree and may be published in appropriate academic journal(s). Further, findings published from this thesis will be shared with service providers and service users through presentations.

I understand that my name will be kept confidential and my responses will be put together with those of other women so that they cannot be attributed to me and I cannot be identified in anyway. My participation is completely voluntary and I can refuse to answer any questions or I can withdraw at any time by informing Mary K Renwick. I understand that participation will not affect any services that I may be using now or in the future. As a consenting participant, I am not waiving any rights to legal recourse in the event of research-related harm. I am aware that should incidence of abuse of an older person become apparent the investigator (Mary K Renwick) is bound by law to report it to the appropriate authorities.

I understand that there will be two interviews scheduled at my convenience. The initial interview will take about an hour and a half of time. A second interview, to clarify and further add any information, will take about an hour and occur at a later date. The interviews may be audio-recorded and transcribed to prepare the information that I share for analysis. However, only the researcher, her supervisor, and the transcriber will have access to these audio-recordings. The transcripts will be coded and my name will not be kept with the transcripts. All data will be destroyed at the end of the research process.

Mary K Renwick, a Psychiatric Nursing Masters student at Brandon University is conducting this study under the supervision of Dr. Fran Racher, Professor of
Nursing Faculty. Should I have any questions or concerns about participating in the study, I will contact Mary K Renwick at (306) 778-5267 or by e-mail at mkren@sasktel.net. I may also contact her supervisor, Fran Racher at (204) 728-4747 or by e-mail at racher@brandonu.ca. If I have any questions or concerns about the ethics of conducting this study I may contact the Brandon University Ethics Committee at (204) 727-9712 or by e-mail at burec@brandonu.ca.

I understand the above information and after being given an opportunity to have my questions answered, I agree to participate in this study.

I understand that I will be given a copy of this completed form and that my consent will be revisited before the second interview.

Participant’s Name (please print)___________________________________

Participant’s Signature _________________________ Date ____________

Researcher’s Signature ________________________ Date ____________
Appendix E

Brandon University

Older Rural Women’s Experiences in Using

Rural Mental Health Services

Confidentiality Agreement

I, _______________________________________________ affirm that I will not disclose or make known any matter or thing related to the participants that comes to my knowledge during this research project.

_____________________________________________          ____________________
Research Assistant                                                                  Date

_____________________________________________          ____________________
Signature of Witness                                                                  Date
Appendix F

Certificate of Completion

Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans

Course on Research Ethics (TCPS 2: CORE)

Certificate of Completion

This document certifies that

Mary K Renwick

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of issue: 13 October, 2014
Appendix G

BRANDON UNIVERSITY RESEARCH ETHICS COMMITTEE (BUREC)
ETHICS CERTIFICATE

Brandon University Research Ethics Committee (BUREC)
For Research Involving Human Participants

ETHICS CERTIFICATE

The following ethics proposal has been approved by the BUREC. The approval is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports. As per BUREC Policies and Procedures, section 6.0, "At a minimum, continuing ethics review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects. Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approval any new research ethics submissions, and/or others as outlined in Section 10.8".

Any changes made to the protocol should be reported to the BUREC prior to implementation. See BUREC Policies and Procedures for more details.

As per BUREC Policies and Procedures, section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the BUREC Policies and Procedures. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

<table>
<thead>
<tr>
<th>Name of Principal Investigator:</th>
<th>Ms Mary Renwick, Brandon University</th>
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</thead>
<tbody>
<tr>
<td>Title of Project:</td>
<td>Older Rural Women's Experiences in Using Rural Mental Health Services</td>
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<tr>
<td>Co-investigator(s):</td>
<td>n/a</td>
</tr>
<tr>
<td>Faculty Supervisor:</td>
<td>Dr. Fran Racher, Faculty of Health Studies, Brandon University</td>
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<td>Research Office File #:</td>
<td>21023 (2014)</td>
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<tr>
<td>Date of Approval:</td>
<td>January 14, 2015</td>
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<td>Ethics Expiry Date:</td>
<td>January 14, 2020</td>
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| Authorizing Signature:        | Dr. Etsuko Yasui  
Co-Chair  
Brandon University Research Ethics Committee |
February 10th, 2015

Mary K Renwick RPN/BScPN
Masters of Psychiatric Nursing Candidate
Dr. Fran Ratcher
Facility Health Studies
Brandon University
do Adult Mental Health
El Wood Building

RE: “Request for Approval for the Study of “Older Rural Women’s Experiences in Using Rural Mental Health Services”

Dear Ms. Renwick:

The Cypress Health Region’s Ethics Committee has reviewed your request for approval of the study of “Older Rural Women’s Experiences in Using Rural Mental Health Services”. The Committee has found your application to be acceptable on ethical grounds. Please be advised that approval has been given. Please ensure that any changes are reported to the Ethics Committee. We also ask that you share with us a summary of your findings as the study progresses.

Sincerely,

Brandy Winquist, MSc, PhD
Chair, Regional Ethics Committee
Decision Support Consultant/ Epidemiologist
Appendix I

Interview Guide

Research Question: What is the lived experience of older women using mental health services in rural communities in southwest Saskatchewan?

The qualitative approach relies on the premise of adjustment and flexibility in data collection depending on information gathered. As such, adaptation of the format is anticipated and appropriate.

Research using phenomenological methods entails asking participants broad and general questions that focuses attention on gathering data to facilitate textual and structural portrayals of the participant's experiences. Concrete questions will be asked to facilitate participants in describing their lived experience of the use of rural mental health services. The principal investigator will collect data from participants through conversational interviews.

To begin I would like to get to know you a little better and would like to hear about your life.

1. How long have you lived in this community?
2. Where did you grow up? When did you move here?
3. What brought you to this community?
4. Do you have family members living nearby?
5. When you need the support of others, who are the people that you count on?
6. If you need to go beyond supportive individuals, where do you go for help?
7. What mental health services have you used in this community? Beyond?
8. What has been effective for you in using these services?
9. What has not worked well in using mental health services in this community?
10. What other resources or strategies do you use to support your mental health?
11. What mental health challenges do you face related to living in this rural community?
12. What do you do to manage these challenges?
13. What else would you like to add?